3) Are YOU now be covered und	getting any trea ler no-fault, auto				r which ar	nother p	arty coul	d be held	responsit	ole or co	uld
YES [NO 🔀		If YES , D	ate of Ill	ness or Inj	jury: L		- D D		YY	Y
If YES, Insu	irer Name										
L DDDEGG										$\perp \perp$	
ADDRESS											
ADDRESS										11	
CITY					STA'	re 	ZIP				
	OF COTTON	C WIFE		******	- L						
		C - INFO	RMAT	ION A	BOUT	YOU	R FAN	IILY N	4EMBI	ER	
1) On $\omega/1/2$ family member?		, will YOU	be receiving	ng any gr	oup healt	h covera	age throu	gh the cu	rrent emp	loyment	of a
	X YES	NO		(If NO	or N/A, S	TOP, s	ign botto	om of for	rm)		
Family Men	nber's Name				Middle						
FIRST BII L		1 1 1		1 1					Security		
LAST	<u> </u>				M	16	[5]	43	-[2]		2
SMII	TIHI			\mathbf{I}	1.1		11				
	ployees work for	or your famil	v member	's employ	er?						
Don't know		or more		ın 100		(If les	s than 10	00, STO 1	P, please s	ign belo	w)
Please provide the	name of the em	ployer, and ir	nformation	about th	e employe	er group	health p	lan in the	e spaces b	elow:	
EMPLOYER I	NAME	1 1 1		1 1					,		
ADDRESS											
CITY					STA	TF	ZIP				
NAME OF HE	EALTH PLAN		1 1 1	1.1	1 1	1 1	1 1		1.1		
ADDŖESŞ ,											
ADDRESS											
								100			
CITY 	1.1.1			1	STA'	TE 	ZIP		1.1	1.1	
GROUP IDEN	TIFICATION N	UMBER									_
POLICY NUM	MBER										
Your Signature Is Required					AREA CO			NUMBE		5 1	
Mary Snuth					33	3-	81	6-	123	54	